

Editorials

Too Many Lawyers?

THE *AMA News* (September 16, 1983) reports that the American Bar Association (ABA) is concerned about the increase in the number of lawyers, having estimated that by the end of 1983 there would be 650,000 lawyers in the United States and by the mid-1990s they will number 1 million. The ABA is worried that this rapid increase in the number of lawyers "may lead to a decline in the image of lawyers and more client complaints if lawyers resort to shortcuts or delay tactics to keep their incomes up, according to *U.S. News and World Report*." There may be others who worry, or ought to be worrying, about the economic impact of such a dramatic increase in the number of lawyers. A more or less comparable percentage increase in the numbers of doctors in more or less the same time frame has caused considerable public discussion about the effect this increase might have on the costs.

A precise breakdown of costs for either the health care system or for the legal system is difficult to come by. At the moment more attention is being given to the costs of health care. Its total costs have been linked to the gross national product and are now said to be more than 10% of it. But it is hard to believe that the total costs of our legal system are not of a similar order of magnitude (even if one chooses to overlook what seem to many to be unconscionable awards in some liability suits), and it is also hard to believe that a rapidly increasing number of lawyers will not have an economic impact upon the total cost of the legal system to the public.

More attention is needed to these issues. The costs of the legal system are surely as important to Americans as is the cost of health care. But the present social and political climate being what it is, it seems unlikely that the legal system and the legal profession will be asked the same kind of questions about costs as are being asked of the health care system and the medical profession. In the meantime there would seem to be many other good reasons to be as worried about there being too many lawyers as is the ABA.

MSMW

The Changing Natural and Surgical History of Abdominal Aortic Aneurysms

THE CAUSE OF ARTERIAL ANEURYSMS, especially aneurysm of the abdominal aorta, is indeed poorly understood, as described elsewhere in this issue by Fortner and Johansen in their comprehensive discussion. Only a relatively small percentage of patients have associated occlusive arteriosclerotic disease of the lower

extremities, but the coincidence of abdominal aortic aneurysm with coronary artery disease is high. It is a verifiable fact that more aneurysms have been identified in elderly patients in the past two decades, but whether this represents the accidental discovery because of more abdominal and back x-ray films, more ultrasonic studies and more computed tomographic (CT) scans, or the increased number of persons reaching geriatric age is uncertain.

Surgical results have improved progressively over the past 20 years. This has influenced the decisions concerning prophylactic surgical procedures. Sixty-year-old patients with small 4- to 5-cm aneurysms some years ago were followed till the aneurysms reached 6 to 8 cm, then operation often became urgent in a 70-year-old patient with chronic heart or lung disease, who was a much less satisfactory candidate. Now, with the firm knowledge that current synthetic grafts are extremely durable and infrequently complicated, we are secure in operating on younger patients with smaller aneurysms. If operation becomes necessary in octogenarians, careful anesthetic control and precise cardiac monitoring to prevent underhydration or overhydration have reduced the morbidity in these persons. The greatest cause of perioperative and postoperative morbidity and mortality in aneurysm patients is myocardial infarction. This has led to the current controversy over whether all asymptomatic patients with aneurysm should have coronary angiograms and a prophylactic coronary artery surgical procedure before the aneurysm is resected. There is much to be said for this approach; on the other hand, current statistics do not prove that all patients with asymptomatic carotid bruits should have carotid endarterectomy because the incidence of stroke associated with aneurysm repair is low.

A simple protocol for evaluating any patient older than 50 years seen to have calcium in the abdominal aorta is to obtain a lateral x-ray film. If the anterior wall of the aorta is clearly outlined—even when the posterior aortic wall cannot be seen—measuring the maximum distance from anterior aorta to the vertebral body gives an accurate estimation of the diameter.¹ If the aortic diameter cannot be measured with certainty on lateral x-ray film, then abdominal ultrasonogram or CT scan should be done. If the aorta is greater than 4 cm in outside diameter by any of these measurements, and if after careful medical evaluation the patient has a life expectancy of three to five years, then a prophylactic operation should be seriously considered.

To echo again the findings of Szilagyi and associates,² prophylactic surgical repair of abdominal aneu-